CITY OF LINCOLN

Supplemental Life Insurance and Accidental Death & Dismemberment Enrollment Form

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Name: _____ **Social Security #:** _____

Salary: _____ **Date of Birth:** _____ **Age:** _____

Date of Hire: _____ **Effective Date:** November 1st, 2006

The following costs should be calculated based on your age as of the plan effective date.

Supplemental Life/AD&D Insurance - Employee

You have the opportunity to enroll in City of Lincoln's Supplemental Life Insurance/AD&D plan. Your election may be made in increments of $10,000, not to exceed 5 times your salary or $500,000, whichever is less. **All Current Employees electing coverage for the first time or Employees electing increased Coverage Amounts must complete the Simplified Medical Underwriting (SMU) Form during the enrollment. Voluntary coverage will be approved, or additional information will be requested based on each individual's responses***. If approved, the Coverage Amount will be the lesser of your election, $250,000 or 5 times your earnings. If you elect an amount over the Coverage Amount, further evidence of good health, that is satisfactory to Hartford Life, will need to be provided before the excess can become effective.

*Note: If at least 42% of eligible employees elect to participate in the Supplemental Life/AD&D plan, you will automatically be approved for coverage up to the lesser of 5 times your earnings or $250,000.

Use the rate chart and calculation line below to determine your Monthly cost for this coverage.*

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	$0.110	$0.110	$0.120	$0.150	$0.200	$0.300	$0.480	$0.720	$1.070	$1.930	$3.340	$5.490

☐ I elect to **enroll** in the Supplemental Life/AD&D plan at the Monthly cost below.*

_____ (Elected Benefit Amount) ÷ $1,000 = _____ x _____ (Rate Above) = $_____ (Your Monthly Cost*)

☐ I elect to **decline** the Supplemental Life/AD&D plan.

*Your cost may change if your age category changes within the benefits plan year.

*Note: Benefit reductions begin at age 70. Please see your benefits administrator for further information.

Supplemental Life/AD&D Insurance - Spouse

If you elect the Supplemental Life/AD&D plan for yourself, you may elect Supplemental Life/AD&D coverage for your Spouse. Your election may be made in increments of $5,000 to a maximum of $100,000 but may not exceed 50% of your approved election. **A Simplified Medical Underwriting (SMU) Form must be completed during the enrollment. Dependent coverage may be contingent upon Employee Supplemental Life coverage AND Spouse response to SMU.** If approved, the Spouse Coverage Amount will be the lesser of your election or $50,000. If an amount over this Coverage Amount is elected, further evidence of good health, that is satisfactory to Hartford Life, will need to be provided before the excess can become effective. **Supplemental Spouse rates and premiums are based on the Spouse's age, not the Employee's age.**

Use the rate chart and calculation line below to determine your Monthly cost for this coverage.*

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	$0.110	$0.110	$0.120	$0.150	$0.200	$0.300	$0.480	$0.720	$1.070	$1.930	$3.340	$5.490

☐ I elect to **enroll** my Spouse in the Supplemental Life/AD&D plan at the Monthly cost below.*

_____ (Elected Benefit Amount) ÷ $1,000 = _____ x _____ (Rate Above) = $_____ (Your Monthly Cost*)

☐ I elect to **decline** the Supplemental Life/AD&D plan for my Spouse.

*Your cost may change if your Spouse's age category changes within the benefits plan year.

SPOUSE:

First Name	Last Name	Gender	Date of Marriage	Date of Birth

Supplemental Life/AD&D Insurance - Child(ren)

If you elect the Supplemental Life/AD&D plan for yourself, you may elect Supplemental Life/AD&D coverage for your Dependent Child(ren) between the ages of 2 weeks and 19 years (24 years if a full time student). Your election may be made in increments of $1,000 to a maximum of $10,000 at the cost per child below. Use the rate chart and calculation line to determine your Monthly cost for this coverage.

Child Life Amount	$1,000	$2,000	$3,000	$4,000	$5,000	$6,000	$7,000	$8,000	$9,000	$10,000
Cost per Child	$0.140	$0.280	$0.420	$0.560	$0.700	$0.840	$0.980	$1.120	$1.260	$1.400

☐ I elect to **enroll** my dependent child(ren) in the Supplemental Life/AD&D plan for $_____ at the Monthly cost below.

_____ (# of Children) x _____ (Cost Per Child Above) = $_____ (Your Monthly Cost)

☐ I elect to **decline** the Supplemental Life/AD&D plan for my dependent child(ren).

CHILD:

First Name	Last Name	Gender	Date of Birth	Benefit Amount

Beneficiary Designation

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies) please indicate their full name, address, social security number, relationship, date of birth and distribution percentage. If the beneficiary is not related either by blood or by marriage, insert the words, "Not Related" next to their stated relationship. If you need assistance, contact your benefits administrator or your own legal counsel. Following are examples of the most common designations:

Primary:

- Mary J. Doe, Wife (not Mrs. John Doe).

Contingent:

- Joseph W. Doe, Son and Jane Doe, Daughter, in equal shares (50%).
- Estate of the Insured.

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for example "33% to Mary Jones, Mother, and 67% to Edith Jones, Wife."

	Full Name	Address	SSN	Relationship	D.O.B.	%
Primary						
Contingent						

The beneficiary for life insurance on the lives of your spouse and children will automatically be you, if surviving, otherwise the estate of the spouse and children, subject to policy provisions. A beneficiary for employee Life Insurance may be changed upon written request.

Employee Confirmation

I have been given the opportunity to enroll in City of Lincoln's Group Supplemental Life/AD&D Insurance plans effective November 1st, 2006. I understand that if I decline now, but later decide to enroll, I will be required to provide evidence of good health that is satisfactory to Hartford Life and understand my request for coverage may be denied.

I authorize my employer to make the appropriate payroll deductions from my wages on a post-tax basis. I am not now disabled and I am performing all the duties of my occupation on a full-time basis.

I am aware that if participation requirements are not met, this plan will not be implemented and the coverage elected will not be in force.

Signature: _____ **Date:** _____

PLEASE SIGN AND RETURN THIS FORM TO WILLIAM THORESON